

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/02/2026
NAME OF PROVIDER OR SUPPLIER SEASONS GARDENS SENIOR RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 17250 SW 137 AVENUE MIAMI, FL 33177			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments A complaint investigation (#2025017725) was conducted at Seasons Gardens Senior Residences from 02/26/2026 through 03/02/2026. The provider had deficiencies at the time of the survey, cited under the re-inspections conducted on the same day (Aspen IDs VY1313, VV3613).	A 000			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE